



Medicare & Medicaid EHR Incentive Programs

Stage 2 NPRM Overview

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Proposed Rule

Everything discussed in this presentation is part of a notice of proposed rulemaking (NPRM).

We encourage anyone interested in Stage 2 of meaningful use to review the NPRM for Stage 2 of meaningful use and the NPRM for the 2014 certification of EHR technology at

CMS Rule: http://www.ofr.gov/OFRUpload/OFRData/2012-04443_PI.pdf

ONC Rule: http://www.ofr.gov/OFRUpload/OFRData/2012-04430_PI.pdf

Comments can be made starting March 7 through May 6 at www.regulations.gov

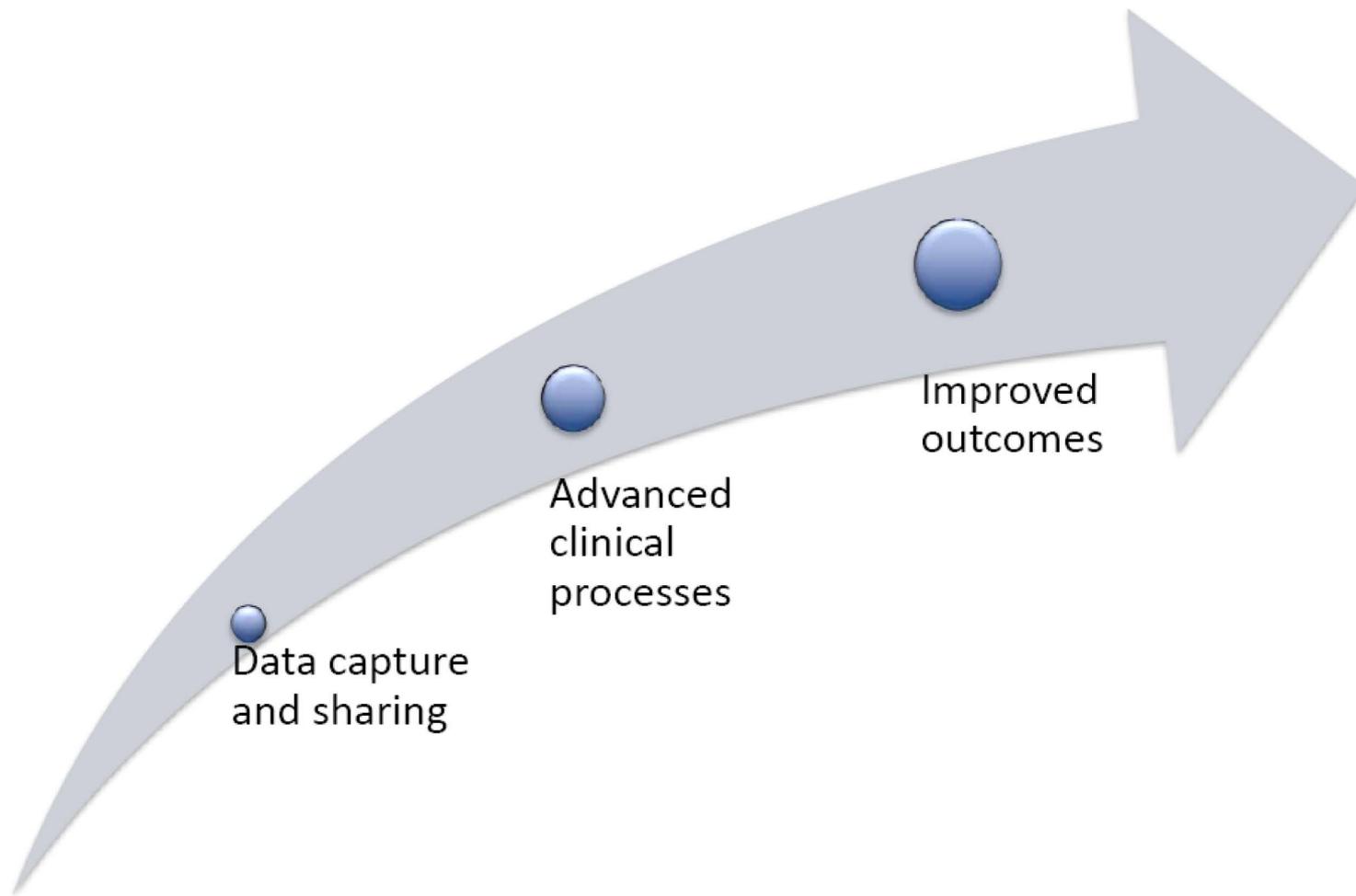


What is in the Proposed Rule

- Minor changes to Stage 1 of meaningful use
- Stage 2 of meaningful use
- New clinical quality measures
- New clinical quality measure reporting mechanisms
- Appeals
- Details on the Medicare payment adjustments
- Minor Medicare Advantage program changes
- Minor Medicaid program changes



A Conceptual Approach to Meaningful Use



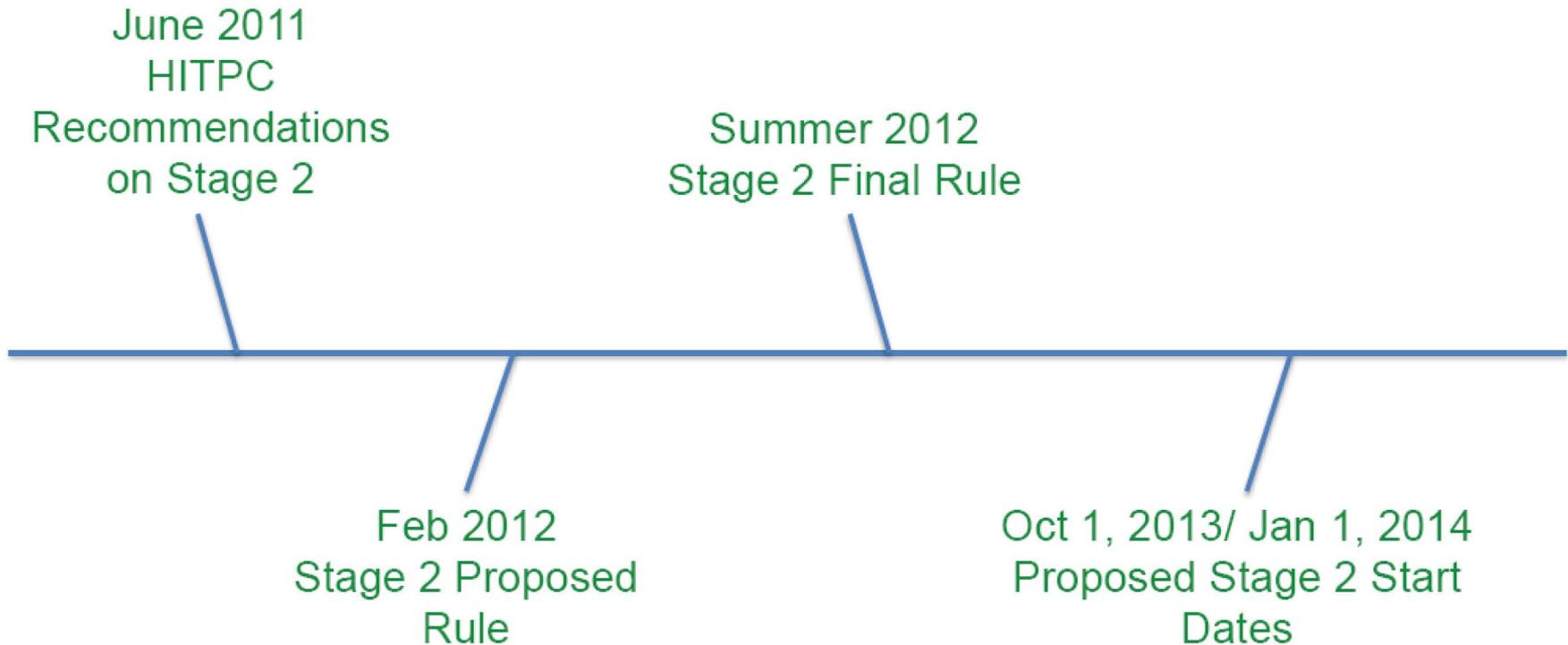
Data capture
and sharing

Advanced
clinical
processes

Improved
outcomes



Stage 2 Timeline





Stages of Meaningful Use

1 st Year	Stage of Meaningful Use										
	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
2011	1	1	1	2	2	3	3	TBD	TBD	TBD	TBD
2012		1	1	2	2	3	3	TBD	TBD	TBD	TBD
2013			1	1	2	2	3	3	TBD	TBD	TBD
2014				1	1	2	2	3	3	TBD	TBD
2015					1	1	2	2	3	3	TBD
2016						1	1	2	2	3	3
2017							1	1	2	2	3



Stage 1 to Stage 2 Meaningful Use

Eligible Professionals

15 core objectives
5 of 10 menu objectives
20 total objectives



Eligible Professionals

17 core objectives
3 of 5 menu objectives
20 total objectives

Eligible Hospitals & CAHs

14 core objectives
5 of 10 menu objectives
19 total objectives



Eligible Hospitals & CAHs

16 core objectives
2 of 4 menu objectives
18 total objectives



Meaningful Use Concepts

Changes

- Exclusions no longer count to meeting one of the menu objectives
- All denominators include all patient encounters at outpatient locations equipped with certified EHR technology

No Changes

- No change in 50% of EP outpatient encounters must occur at locations equipped with certified EHR technology
- Measure compliance = objective compliance



Stage 2 EP Core Objectives

1. Use CPOE for more than **60%** of medication, **laboratory and radiology** orders
2. E-Rx for more than **50%**
3. Record demographics for more than **80%**
4. Record vital signs for more than **80%**
5. Record smoking status for more than **80%**
6. Implement **5** clinical decision support interventions + drug/drug and drug/allergy
7. Incorporate lab results for more than **55%**



Stage 2 EP Core Objectives

8. Generate patient list by specific condition
9. Use EHR to identify and provide more than 10% with reminders for preventive/follow-up
10. Provide **online access** to health information for more than 50% with more than **10% actually accessing**
11. Provide office visit summaries in **24 hours**
12. Use EHR to identify and provide education resources more than 10%



Stage 2 EP Core Objectives

13. **More than 10% of patients send secure messages to their EP**
14. Medication reconciliation at more than **65%** of transitions of care
15. Provide summary of care document for more than **65%** of transitions of care and referrals with **10% sent electronically**
16. **Successful ongoing** transmission of immunization data
17. Conduct or review security analysis and incorporate in risk management process



Stage 2 EP Menu Objectives

- 1. More than 40% of imaging results are accessible through Certified EHR Technology**
- 2. Record family health history for more than 20%**
- 3. Successful ongoing transmission of syndromic surveillance data**
- 4. Successful ongoing transmission of cancer case information**
- 5. Successful ongoing transmission of data to a specialized registry**



Stage 2 Hospital Core Objectives

1. Use CPOE for more than **60%** of medication, **laboratory and radiology** orders
2. Record demographics for more than **80%**
3. Record vital signs for more than **80%**
4. Record smoking status for more than **80%**
5. Implement **5** clinical decision support interventions + drug/drug and drug/allergy
6. Incorporate lab results for more than **55%**



Stage 2 Hospital Core Objectives

7. Generate patient list by specific condition
8. **EMAR is implemented and used for more than 10% of medication orders**
9. Provide **online access** to health information for more than 50% with more than **10% actually accessing**
10. Use EHR to identify and provide education resources more than 10%
11. Medication reconciliation at more than **65%** of transitions of care



Stage 2 Hospital Core Objectives

12. Provide summary of care document for more than **65%** of transitions of care and referrals with **10% sent electronically**
13. **Successful ongoing** transmission of immunization data
14. **Successful ongoing** submission of reportable laboratory results
15. **Successful ongoing** submission of electronic syndromic surveillance data
16. Conduct or review security analysis and incorporate in risk management process



Stage 2 Hospital Menu Objectives

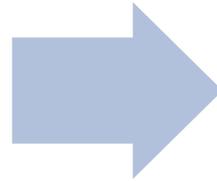
1. Record indication of advanced directive for more than 50%
2. More than 40% of imaging results are accessible through Certified EHR Technology
3. Record family health history for more than 20%
4. E-Rx for more than 10% of discharge prescriptions



Changes to Stage 1

CPOE

Denominator: Unique Patient with at least one medication in their med list

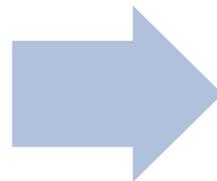


Denominator: Number of Orders during the EHR Reporting Period

Optional in 2013 Required in 2014+

Vital Signs

Age Limits: Age 2 for Blood Pressure & Height/Weight



Age Limits: Age 3 for Blood Pressure, No age limit for Height/Weight

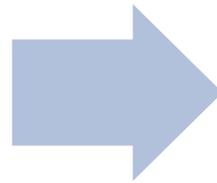
Optional in 2013 Required in 2014+



Changes to Stage 1

Vital Signs

Exclusion: All three elements not relevant to scope of practice

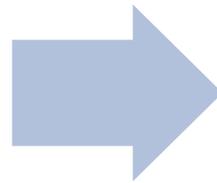


Exclusion: Allows BP to be separated from height/weight

Optional in 2013 Required in 2014+

Test of Health Information Exchange

One test of electronic transmission of key clinical information



Requirement removed effective 2013

Effective 2013

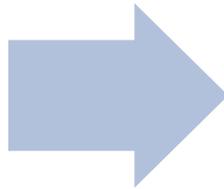


Changes to Stage 1

E-Copy and Online Access

Objective: Provide patients with e-copy of health information upon request

Objective: Provide electronic access to health information



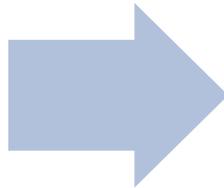
Replacement Objective:

Provide patients the ability to view online, download and transmit their health information

Required in 2014+

Public Health Objectives

Immunizations
Reportable Labs
Syndromic Surveillance



Addition of “except where prohibited” to all three

Effective 2013



CLINICAL QUALITY MEASURES



Clinical Quality Measures

Change from Stage 1 to Stage 2:

CQMs are no longer a meaningful use core objective, but reporting CQMs is still a requirement for meaningful use.



CQM – Timing

Time periods for reporting CQMs – NO CHANGE from Stage 1 to Stage 2

Provider Type	Reporting Period for 1 st year of MU (Stage 1)	Submission Period for 1 st year of MU (Stage 1)	Reporting Period for Subsequent years of MU (2 nd year and beyond)	Submission Period for Subsequent years of MU (2 nd year and beyond)
EP	90 consecutive days within the calendar year	Anytime immediately following the end of the 90-day reporting period , but no later than February 28 of the following calendar year	1 calendar year (January 1 – December 31)	2 months following the end of the EHR reporting period (January 1 – February 28)
Eligible Hospital/ CAH	90 consecutive days within the fiscal year	Anytime immediately following the end of the 90-day reporting period , but no later than November 30 of the following fiscal year	1 fiscal year (October 1 – September 30)	2 months following the end of the EHR reporting period (October 1 – November 30)



Alignment Among Programs

- CMS is committed to aligning quality measurement and reporting among programs
- Alignment efforts on several fronts:
 - Choosing the same measures for different program measure sets
 - Coordinating quality measurement stakeholder involvement efforts and opportunities for public input
 - Identifying ways to minimize multiple submission requirements and mechanisms



Alignment Among Programs (cont'd)

- Lessen provider burden
- Harmonize with data exchange priorities
- Support primary goal of all CMS quality measurement programs
 - Transforming our health care system to provide:
 - Higher quality care
 - Better health outcomes
 - Lower cost through improvement



CQM Priorities

- Making care safer by reducing harm caused in the delivery of care.
- Ensuring that each person and family are engaged as partners in their care.
- Promoting effective communication and coordination of care.



CQM Priorities (cont'd)

- Promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease.
- Working with communities to promote wide use of best practices to enable healthy living.
- Making quality care more affordable for individuals, families, employers, and governments by developing and spreading new health care delivery models.



CQM - Domains

- Patient and Family Engagement
- Patient Safety
- Care Coordination
- Population and Public Health
- Efficient Use of Healthcare Resources
- Clinical Processes/Effectiveness



CQM - Changes from July 28, 2010 Final Rule

2010 Final Rule

Eligible Professionals

3 core OR 3 alt. core CQMs

+

3 menu CQMs

6 total CQMs



Eligible Hospitals & CAHs

15 total CQMs



2012 Proposed Rule

Eligible Professionals

1a) 12 CQMs (≥ 1 per domain)

1b) 11 core + 1 menu CQMs

2) PQRS

Group Reporting

12 total CQMs

Eligible Hospitals & CAHs

24 CQMs (≥ 1 per domain)

24 total CQMs

Align with ONC's

2011 Edition Certification

Align with ONC's

2014 Edition Certification



CQM Reporting in 2013 EPs & Hospitals

- CQMs will remain the same through 2013
 - As published in the July 28, 2010 Final Rule
- Electronic specifications for the CQMs will be updated
- Reporting Methods:
 - 1) Attestation
 - 2) 2012 Electronic Reporting Pilots extended to 2013
 - 3) Medicaid – State-based e-submission



CQM Reporting for EPs Beginning in CY2014

- EHR Incentive Program Only
 - Option 1a: 12 CQMs, ≥ 1 from each domain
 - Option 1b: 11 “core” CQMs + 1 “menu” CQM
 - Medicaid – State based e-submission
 - Aggregate XML-based format specified by CMS
- EHR Incentive Program + PQRS
 - Option 2: Submit and satisfactorily report CQMs under PQRS EHR Reporting option using CEHRT
 - Requirements for PQRS are in CY 2012 Medicare Physician Fee Schedule final rule (76 FR 73314)



CQM Reporting for EPs Beginning in CY2014

- Group Reporting (3 options):

(1) ≥ 2 EPs, each with a unique NPI under one TIN	Submit 12 CQMs from EP measures table, ≥ 1 from each domain
(2) EPs in an ACO (Medicare Shared Savings Program)	Satisfy requirements of Medicare Shared Savings Program using Certified EHR Technology
(3) EPs satisfactorily reporting via PQRS GPRO option	Satisfy requirements of PQRS GPRO option using Certified EHR Technology



CQM Reporting for Hospitals Beginning in FY2014

- 24 CQMs, ≥ 1 from each domain
 - Includes 15 CQMs from July 28, 2010 Final Rule
 - Considering instituting a case number threshold exemption for some hospitals
- Reporting Methods
 - 1) Aggregate XML-based format specified by CMS
 - 2) Manner similar to 2012 Medicare EHR Incentive Program Electronic Reporting Pilot
 - Requirements for pilot in CY 2012 Outpatient Prospective Payment System (76 FR 74122)



Medicare Only

EPs, Subsection (d) Hospitals and CAHs

PAYMENT ADJUSTMENTS



Payment Adjustments

- The HITECH Act stipulates that for Medicare EP, subsection (d) hospitals and CAHs a payment adjustment applies if they are not a meaningful EHR user.
- An EP, subsection (d) hospital or CAH becomes a meaningful EHR user when they successfully attest to meaningful use under either the Medicare or Medicaid EHR incentive program
- As adopt, implement and upgrade does not constitute meaningful use, a provider receiving a Medicaid incentive for AIU would still be subject to the Medicare payment adjustment.



EP Payment Adjustments

% ADJUSTMENT ASSUMING LESS THAN 75 PERCENT OF EPs ARE MEANINGFUL EHR USERS FOR CY 2018 AND SUBSEQUENT YEARS

	2015	2016	2017	2018	2019	2020+
EP is not subject to the payment adjustment for e-Rx in 2014	99%	98%	97%	96%	95%	95%
EP is subject to the payment adjustment for e-Rx in 2014	98%	98%	97%	96%	95%	95%

% ADJUSTMENT ASSUMING MORE THAN 75 PERCENT OF EPs ARE MEANINGFUL EHR USERS FOR CY 2018 AND SUBSEQUENT YEARS

	2015	2016	2017	2018	2019	2020+
EP is not subject to the payment adjustment for e-Rx in 2014	99%	98%	97%	97%	97%	97%
EP is subject to the payment adjustment for e-Rx in 2014	98%	98%	97%	97%	97%	97%



Subsection (d) Hospital Payment Adjustments

% Decrease in the Percentage Increase to the IPPS Payment Rate that the hospital would otherwise receive for that year

	2015	2016	2017	2018	2019	2020+
% Decrease	25%	50%	75%	75%	75%	75%

For example if the increase to IPPS for 2015 was 2% than a hospital subject to the payment adjustment would only receive a 1.5% increase



Critical Access Hospital (CAH) Payment Adjustments

**Applicable % of reasonable costs reimbursement
which absent payment adjustments is 101%**

	2015	2016	2017	2018	2019	2020+
% of reasonable costs	100.66%	100.33%	100%	100%	100%	100%



EP EHR Reporting Period

EP who has demonstrated meaningful use in 2011 or 2012

Payment Adjustment Year	2015	2016	2017	2018	2019	2020
Full Year EHR Reporting Period	2013	2014	2015	2016	2017	2019

EP who demonstrates meaningful use in 2013 for the first time

Payment Adjustment Year	2015	2016	2017	2018	2019	2020
90 day EHR Reporting Period	2013					
Full Year EHR Reporting Period		2014	2015	2016	2017	2019



EP EHR Reporting Period

EP who demonstrates meaningful use in 2014 for the first time

Payment Adjustment Year	2015	2016	2017	2018	2019	2020
90 day EHR Reporting Period	2014*	2014				
Full Year EHR Reporting Period			2015	2016	2017	2019

*In order to avoid the 2015 payment adjustment the EP must attest no later than Oct 1, 2014 which means they must begin their 90 day EHR reporting period no later than July 2, 2014



Subsection (d) Hospital EHR Reporting Period

Hospital who has demonstrated meaningful use in
2011 or 2012 (fiscal years)

Payment Adjustment Year	2015	2016	2017	2018	2019	2020
Full Year EHR Reporting Period	2013	2014	2015	2016	2017	2019

Hospital who demonstrates meaningful use in
2013 for the first time

Payment Adjustment Year	2015	2016	2017	2018	2019	2020
90 day EHR Reporting Period	2013					
Full Year EHR Reporting Period		2014	2015	2016	2017	2019



Subsection (d) Hospital EHR Reporting Period

Hospital who demonstrates meaningful use in
2014 for the first time

Payment Adjustment Year	2015	2016	2017	2018	2019	2020
90 day EHR Reporting Period	2014*	2014				
Full Year EHR Reporting Period			2015	2016	2017	2019

*In order to avoid the 2015 payment adjustment the hospital must attest no later than July 1, 2014 which means they must begin their 90 day EHR reporting period no later than April 1, 2014



EP Hardship Exception

Proposed Exception on an application basis

- Insufficient internet access two years prior to the payment adjustment year
- Newly practicing EPs for two years
- Extreme circumstances such as unexpected closures, natural disaster, EHR vendor going out of business, etc.

Applications need to be submitted no later than July 1 of year before the payment adjustment year; however, we encourage earlier submission



EP Hardship Exception

Other Possible Exception Discussed in NPRM

- Concerned that the combination of 3 barriers would constitute a significant hardship
 - Lack of direct interaction with patients
 - Lack of need for follow-up care for patients
 - Lack of control over the availability of Certified EHR Technology
- We do not believe any one of these barriers taken independently constitutes a significant hardship
- In our discussion we consider whether any specialty may nearly uniformly face all 3 barriers



Subsection (d) Hospital Hardship Exception

Proposed Exception on an application basis

- Insufficient internet access two years prior to the payment adjustment year
- New hospitals for at least 1 full year cost reporting period
- Extreme circumstances such as unexpected closures, natural disaster, EHR vendor going out of business, etc.

Applications need to be submitted no later than April 1 of year before the payment adjustment year; however, we encourage earlier submission



CAH EHR Reporting Period

CAH who has demonstrated meaningful use prior to 2015 (fiscal years)

Payment Adjustment Year	2015	2016	2017	2018	2019	2020
Full Year EHR Reporting Period	2015	2016	2017	2018	2019	2020

CAH who demonstrates meaningful use in 2015 for the first time

Payment Adjustment Year	2015	2016	2017	2018	2019	2020
90 day EHR Reporting Period	2015					
Full Year EHR Reporting Period		2016	2017	2018	2019	2020



CAH Hardship Exception

Proposed Exemptions on an application basis

- Insufficient internet access for the payment adjustment year
- New CAHs for one year after they accept their first patient
- Extreme circumstances such as unexpected closures, natural disaster, EHR vendor going out of business, etc.



MEDICAID-SPECIFIC CHANGES



Medicaid- Specific Changes

- Proposed an expanded definition of a Medicaid encounter:
 - To include any encounter with an individual receiving medical assistance under 1905(b), including Medicaid expansion populations
 - To permit inclusion of patients on panels seen within 24 months instead of just 12
 - To permit patient volume to be calculated from the most recent 12 months, instead of on the CY
 - To include zero-pay Medicaid claims



Medicaid-Specific Changes Continued

- Proposed the inclusion of additional children's hospitals that do not have a CMS Certification Number (CCN)
- Proposed to extend States' flexibility with the definition of meaningful use to Stage 2